

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08546

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges.

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 8 mos., 21 days

Hospital, institution, or street address where death occurred:..... Glenn Dale Sanatorium

How long in hospital or institution?..... 8 mos., 21 days

3. (a) FULL NAME

MORTON. ASKEW.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Negro

Separated

6. (b) Name of husband or wife..... Beatrice Battle

7. Birth date of deceased (mo., day, yr.)..... September 6, 1922

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
25 25 11 18 hrs. min.9. Birthplace..... Portsmouth, Virginia
(Town, county, and state)

10. Usual occupation..... Clerk, Food Market

11. Industry or business

Ira Askew

MOTHER FATHER

Windsor, North Carolina

14. Maiden name

Kattie Luton

15. Birthplace

Palstry, North Carolina

16. Informant..... Deceased

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof..... Aug 24, 1948

(month) (day) (year)

Cemetery or crematory

Location..... Arlington, Va.

18. Funeral director

Address..... James E. Finnegan, Jr.

19. Aug 24, 1948. Roseland S. Phillips

(Date record by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C.

County.....

Washington

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No..... I.M.C.A., 12th Street, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

231-03-4550

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

August 24th 1948, at 7:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 2nd 1947, to Aug 24 1948, and that I last saw him alive on Aug 24 1948

Immediate cause of death.....

Pneumonia, Tuber. cecoris

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

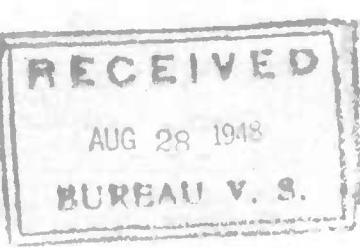
Injured at work?

23. SIGNATURE..... Daniel Leo Finnegan M.D.

M. D. or other

Address..... Glenn Dale, Md.

Date signed..... Aug 24, 1948





Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

18ba
ALM No. G 117 SEP 22 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 245

08547

1. PLACE OF DEATH:

County: Prince George's

City or town: Wooddale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 hours

Hospital, Institution, or street address where death occurred:

Seland Memorial Hosp.

How long in hospital or institution?

3. (a) FULL NAME

Jack S. Barnett

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Colored Married

6. (b) Name of husband or wife

Parolee Barnett

6. (c) If alive, give age 50? years

7. Birth date of deceased (mo., day, yr.)

May 3, 1888

8. AGE:

Years 60

Months 6

Days 13

If less than one day

hrs. min.

9. Birthplace

Penn. (Town, county, and state)

10. Usual occupation

Stone Mason

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Lawrence C. Barnett

Address Ohio

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 3 Sept 1948
(month day year)

Cemetery or crematory Arlington Nat. Cemetery

Location Arlington Va.

18. Funeral director

J. J. Masch's Sons

Address 4239 Baltimore Ave. Hyattsville Md.

19. Sept 3, 1948 Mrs. J. S. Barnett
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D.C.

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 1612 Del. Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war W.W.I

3. (b) Social Security Number

579-05-5878

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Aug

1948 at 1 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on

Immediate cause of death Retropertitoneal hemorrhage & shock

Due to Multiple fractures of pelvis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8/30/48

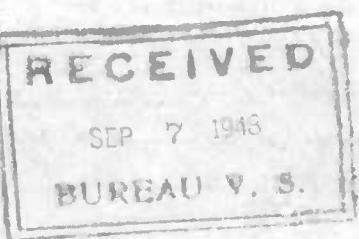
Where did injury occur? Ft. Lincoln Cemetery (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Fell 25 ft. from scaffold Injured at work?

23. SIGNATURE John J. Maloney Deputy Med. Examiner

Address Cheverly - Maryland M. D. or other Date signed 9-2-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08548
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH:
Prince Georges Co.

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Peter Paul Beach

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) **Aug; 23, 1871**

8. AGE: Years	Months	Days	If less than one day
76 ?	0	1	hrs. min.

9. Birthplace.....
(Town, county, and state)
Mt. Clements, Mich.

10. Usual occupation.....
Retired

11. Industry or business
Peter Paul Beach, Sr.

MOTHER FATHER
12. Name.....
Mich.

13. Birthplace.....
Unknown know

14. Maiden name.....
Mich

15. Birthplace.....
Mary C. Beach

16. Informant.....
Address.....
Daniels Park, Maryland

17. Burial.....
(Burial, cremation, or removal. Which?)
Burial Date thereof.....
(month) (day) (year)
Aug. 27 1948

Cemetery or crematory.....
Ceder Hill

Location.....
Suitland, Maryland

18. Funeral director.....
Address.....
J. Gascia Sons

19. Address.....
Hyattsville, Md.

20. Date record by registrar.....
August 26th 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....
Maryland County.....
Pr. Geo. Co.

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH **Aug. 24 1948** at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., 10....., 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Coronary Occlusion

Due to.....

My pernicious heart disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

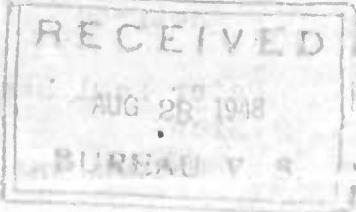
Means of injury..... Injured at work?

23. SIGNATURE.....
John J. Maloney, Examiner

M. D. or other

Date signed.....
8-25-48

Address.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08550

CERTIFICATE OF DEATH

Reg. Dist. No. 265

131a

1. PLACE OF DEATH:

County.

City or town.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 4 mos.

Hospital, institution, or street address where death occurred:

Sacred Heart Home

How long in hospital or institution? 3 yrs 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. 15 Bryant N.W. County Wash. D.C.

City or town. Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Bryant St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

John T. Brown

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife

Mary B. Johnson

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

August 10, 1862

8. AGE:

Years 86 - Months 19 Days hrs. min.

9. Birthplace

Washington, D.C.

10. Usual occupation

retired

11. Industry or business

Thomas Brown

12. Name

V.A.

13. Birthplace

V.A.

14. Maiden name

Frances Partridge

15. Birthplace

V.A.

16. Informant

Sacred Heart Home

Address

5805 Queen Chapel Rd.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Glenwood Cemetery

Location

W.W. & Sons

18. Funeral director

300 4th St. N.E.

Address

(Date rec'd by registrar)

Aug 29

19. Registrar

James Savay

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1948 at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 1 1948 to Aug. 29 1948

and that I last saw h. in alive on Aug. 28 1948

Immediate cause of death Cerebral vascular

Renal Disease

Q. Sore Throat

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

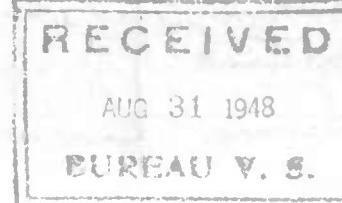
23. SIGNATURE... P.S. Williams, M.D.

M. D. or other

Address 35 New York Avenue Date signed 8/29/48

1666 - Varnum Pl.
N.C.

Dr. Williams



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08551

CERTIFICATE OF DEATH

Reg. Dist. No.

234

1. PLACE OF DEATH:

County..... Prince George

City or town..... Accotink

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Amelia Davis Burns.

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Col.

Widowed

6. (b) Name of husband or wife

Caleb Burns.

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

April 18, 1875

8. AGE:

Years

Months

Days

If less than one day

73

3

22

hrs.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Housewife

Own Home.

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 13 1948

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

Aug. 12 1948 M. A. Johnson

Baptist

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Prince George

City or town.....

Linthicum

Street No.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

2d. DATE OF DEATH

August 10 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1948 to August 10 1948

and that I last saw h. alive on

Immediate cause of death

Cerebral Hemorrhage

DURATION

1yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank G. Susan Jr.

M. D. or other

Address Indian Head Md. Date signed 8-10-48

RECEIVED
AUG 17 1948
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08549

CERTIFICATE OF DEATH

45f
Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 mos., 24 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 6 mos., 24 days

3. (a) FULL NAME

Virginia Cartwright

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Negro

Widowed

6. (b) Name of husband or wife..... Sam Cartwright

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... March 1, 1891

8. AGE: Years Months Days If less than one day

57 57 5 16 hrs. min.

9. Birthplace..... Starkville, Mississippi

(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Robert Kincaid

13. Birthplace..... Starkville, Mississippi

14. Maiden name..... Nancy Rodney

15. Birthplace..... Starkville, Mississippi

16. Informant..... Deceased

Address

17. Burial, cremation, or removal. Which? (Date thereof) Aug 17 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director..... Hall Bros

Address..... 621 Flora Ave NW Wash DC

8/17 1948 Rowland S. Phillips

19. (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1605 Lincoln Road, N. E.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Aug 17 1948 11:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/23 1948 to 8/17 1948

and that I last saw her alive on 8/17/48 1948

Immediate cause of death.....

Pulmonary Tubercolosis

DURATION

9 mos.

Due to.....

Due to.....

Other conditions..... *Carcinoma of throat*

9 mos.

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... *Daniel Leo Kincaid MD*

M. D. or other

Address..... Glenn Dale, Md. Date signed Aug 17, 1948

RECEIVED
AUG 26 1948
BUREAU Y. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08552

46e

Reg. Dist. No. 245

1. PLACE OF DEATH:

County

Prince Georges
Brentwood Md

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

37 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age

years

Dec 10, 1891

8. AGE:

Years

Months

Days

If less than one day

57

hrs.

min.

9. Birthplace

(Town, county, and state)

Washington D.C.

Mechanic

10. Usual occupation

11. Industry or business

MOTHER FATHER

Name

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

Burial

(Burial, cremation, or removal Which?)

Cemetery or crematory

Location

17. Date thereof

(month)

(day)

(year)

Injured at home, farm, industry, pub'l place (where?)

Means of injury

Injured at work?

Date of

(City or town)

(County)

(State)

Date signed

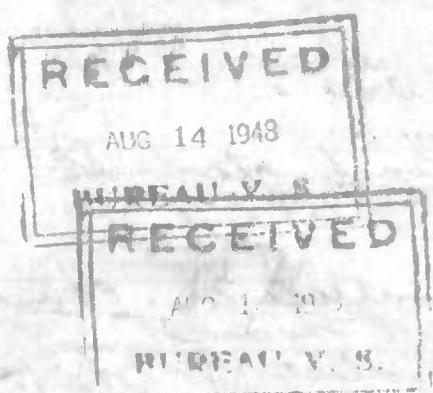
M. D. or other

Date signed

Place of death

Date signed

Signature



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

08553

CERTIFICATE OF DEATH

Reg. Dist. No. 2581

1. PLACE OF DEATH:

County Prince George's

City or town Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days 7 hours

Hospital, institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 10 days 7 hours

3. (a) FULL NAME

Hans Coates

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Widowed

6. (b) Name of husband or wife

Ellen J. Coates

7. Birth date of deceased (mo., day, yr.)

June 4, 1873

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

75

2

5

hrs.

min.

9. Birthplace

(Town, county, and state)

Va

10. Usual occupation

Retired

11. Industry or business

U.S. Govt.

12. Name

Carter Coates

13. Birthplace

Va

14. Maiden name

Marie Styson Va

15. Birthplace

Va

16. Informant

Lloyd Coates

Address Hyattsville Md

17. Burial

Date thereof Aug 12, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St Lincoln

Location

Colmar Manor Md

18. Funeral director

Z Gasche son

Address

Hyattsville Md

19. Date rec'd by registrar

Aug 12, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Prince George's

City or town Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4207 Kennedy St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

Aug 9.

1948 at 7:22 P.M.

2D. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw h..... alive on.....

Immediate cause of death

PROBABLE ACUTE OILATATION OF HEART.

Due to CORONARY + ARTERIO SCLEROTIC HEART DISEASE + RENAL INSUFFICIENCY

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Leslie French M.D.

M. D. or other

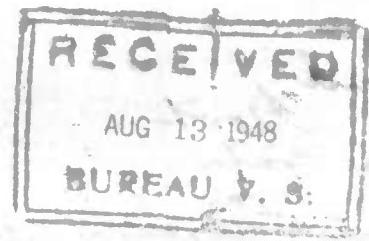
Address

1726 EYE ST. NW

Date signed

10 AUG 1948

WASHINGTON DC



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct, legible, and especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08554

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:

County.....

Prince Georges -

City or town.....

Brandywine -
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

30 years

Hospital, Institution, or street address where death occurred:

Brandywine -

How long in hospital or institution?.....

None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Prince Georges

City or town.....

Brandywine

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

No.

3. (a) FULL NAME

Connick, RICHARD MANOR

3. (b) Social Security Number

No.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

W

MARRIED

6.(b) Name of husband or wife.....

BESSIE HYDE Connick

7. Birth date of deceased (mo., day, yr.)

Jan. 25, 1873

6.(c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

75

6

18

hrs.

min.

9. Birthplace.....

Aquia, Md.

(Town, county, and state)

10. Usual occupation.....

Retired Farmer

11. Industry or business

MOTHER FATHER

12. Name.....

Columbus F. Connick

13. Birthplace.....

Aquia, Md.

14. Maiden name.....

Rebecca H. Scott

15. Birthplace.....

Aquia, Md.

16. Informant.....

Alice Elizabeth Porter

Address.....

6911 Dartmouth Ave. College Pk, Md.

17. Burial.....

Aug. 16, 1948

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

M.D. or other

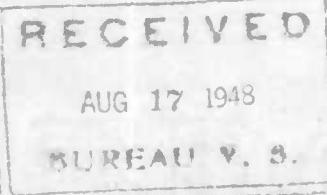
Address.....

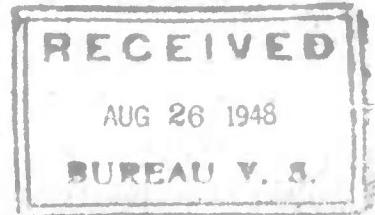
Date signed.....

Aug. 15, 1948

F.H. Billingsley

Registrar





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08556

159

CERTIFICATE OF DEATH

Reg. Dist. No. 215

MARGIN RESERVED FOR BINDING
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
 is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Prince George
 City or town Riverdale Md
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 5 hrs 9 min

Hospital, institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution? 6 5 hrs 9 min

3. (a) FULL NAME

Baby girl Braun, CAROL ELAINE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

4	W	new born
---	---	----------

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day. yr.)

6. (c) If alive, give age years

Aug 2 1948

8. AGE: Years Months Days If less than one day

2 175 hrs 9 min

9. Birthplace

Riverdale Maryland
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Carl Edgar Braun

13. Birthplace Virginia

14. Maiden name Heimra Elaine Myers

15. Birthplace Virginia

16. Informant Hospital record

Address

Burial Date thereof Aug 7, 1948
 (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location Bladensburg Md

18. Funeral director S. Gosch's sons

Address Synderville Md

19. Aug 6 1948 James Derry

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Old Rainier
 (If outside city or town limits, write RURAL and give nearest town)Street No. 4305 Easlera Ave
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1948 at 6 35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 7 1948 to Aug 5 1948
 and that I last saw her alive on Aug 5 1948

Immediate cause of death

Prematurity
 6 1/2 mo twin

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

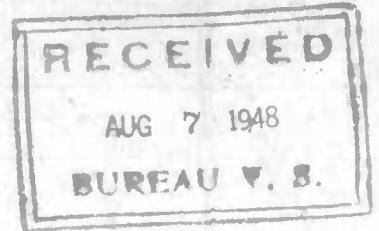
Injured at work?

23. SIGNATURE

M. D. or other

Address Revereval, Md. 8-5-48

Signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08557

245

Reg. Dist. No.

93d

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or street address where death occurred:

Sacred Heart Home

How long in hospital or institution? 11 years

3. (a) FULL NAME

Patrick G. Danaher

4. Sex

m

5. Color or race

W-

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April 19, 1864.

6.(c) If alive, give age years

8. AGE:

84

4

1

hrs. min.

9. Birthplace

Washington D.C.

(town, county, and state)

10. Usual occupation

11. Industry or business

Thomas Danaher

12. Name

Ireland

13. Birthplace

Graig M. Mamara

14. Maiden name

Ireland

15. Birthplace

Records of Sacred Heart

16. Informant

Burial

(Burial, cremation, or removal, which?)

Date thereof 8-24-48

(month) (day) (year)

Cemetery or crematory

Mt. Olivet Cemetery

Location

Washington, D.C.

18. Funeral director

J. Shanahan & Sons Co.

Address

300 - 4th St. N.E. D.C.

Aug 21 1948 Amanda A. Donohue

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Prince Georges

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

5805

- Dennis Chapel Road.

(If rural, give LOCATION)

2.(a) If veteran, name war Spanish American

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 20 1948 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

19.

and that I last saw h alive on

19.

Immediate cause of death

Chronic Myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. Maloney, Dep. Med. Examiner

M. D. or other

Address

Cheverly, Md.

Date signed 8-20-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08558

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH: Prince Georges
County Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 hours, 15 min.
Hospital, institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution? 17 hours, 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Wash. D.C. County
City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 308 F. Street, N.W.
(If rural, give LOCATION)

3. (a) FULL NAME
Patrick Emmet Dunn
4. Sex Male **5. Color or race** White **6. (a) Single, married, widowed, or divorced** Married

6. (b) Name of husband or wife Mary E. Dunn
7. Birth date of deceased (mo., day, yr.) December 18, 1890
6. (c) If alive, give age years

8. AGE: Years 57 Months 8 Days 7 If less than one day hrs. min.

9. Birthplace Granville, Iowa
(Town, county, and state)

10. Usual occupation Accountant

11. Industry or business

MOTHER FATHER Peter Dunn
Name: Peter Dunn
12. Name: Ireland
13. Birthplace

Elizabeth Farrell
14. Maiden name: Elizabeth Farrell
15. Birthplace: Pennsylvania

16. Informant: Mary L. Chadwick
Address: 637 Gallatin Street

Transportation: Date thereof: Aug 28, 1948
(Burial, cremation, or removal. Which?) Green Castle
(month) (day) (year)

Cemetery or crematory: Indiana

Location: F. Gaech's sons

18. Funeral director: Hyattsville Md.

Address: 8/28 1948 Amande Doroney
(Date rec'd by registrar)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 1948 at 5.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19.

and that I last saw h alive on 19.

Immediate cause of death: Mesenteric Thrombosis

Toxemia

Due to: _____

Due to: _____

Other conditions: Purulent Lepto Meningitis.

(Include pregnancy within 3 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: Same Date _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John J. Maloney, M.D. Edam

M. D. or other

Date signed: 8-26-48

RECEIVED
AUG 31 1948
BUREAU V. S.

4-
age M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08559

CERTIFICATE OF DEATH

1700

281

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

45 minutes

Hospital, institution, or street address where death occurred:

Prince Georges Hospital

How long in hospital or institution?.....

45 minutes

3. (a) FULL NAME

Eaton, Mrs. Madeline

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife.....

Charles Eaton

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Nov. 26, 1921

8. AGE: Years

Months

Days

If less than one day

26

9

17

hrs.

min.

9. Birthplace.....

Alexandria Va

(Town, county, and state)

10. Usual occupation.....

House-wife

11. Industry or business

Dungerfield Barrett

FATHER

12. Name.....

Virginia

13. Birthplace.....

Mary O'Connor

14. Maiden name.....

Wash. D.C.

15. Birthplace.....

16. Informant.....

Husband

Address.....

4597 Shaw Drive

17. Burial

Date thereof Aug 17, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

St Lincoln

Location.....

Colmar Manor Md

18. Funeral director.....

Z Gaschi Sons

Address.....

Hyattsville Md.

19. Date rec'd by registrar

19

48

Amanda O'Conor

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

DC

County.....

City or town.....

Glenview Ter. DC

Street No.

4597 Shaw Drive

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

2D. DATE OF DEATH

August 13 1948 at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

19.....

and that I last saw h..... alive on

19.....

Immediate cause of death Fracture base of skull & intracranial hemorrhage

Due to Cerebral concussion

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Aug 13, 1948

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Baltimore Highway

Means of injury Fell from auto.

Injured at work?

23. SIGNATURE

John J. Maloney, Examiner

M. D. or other

Address Cheverly-Hyattsville Date signed 8-13-48

RECEIVED

AUG 19 1948

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 239

45c

08567

1. PLACE OF DEATH:
County. PRINCE GEORGE'S
City or town. AMMENDALE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex M	5. Color or race W	6. (a) Single, married, widowed, or divorced Single
----------	--------------------	---

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec 7 1872

6. (c) If alive, give age... years

8. AGE: Years 75 Months Days If less than one day hrs. min.

9. Birthplace PHILADELPHIA

(Town, county, and state)

10. Usual occupation TEACHER RETIRED

11. Industry or business

FATHER	12. Name NOT KNOWN
	13. Birthplace

MOTHER	14. Maiden name NOT KNOWN
	15. Birthplace

16. Informant BRO F JAMES

Address AMMENDALE

17. BURIAL Date thereof SEPT 1 48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory AMMENDALE

Location AMMENDALE MD

18. Funeral director W W Chamber Co

Address Riverdale Md

19. (Date rec'd by registrar) Aug 29 1948 M. Bushnell

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State MD County Prince George's

City or town BURMESTER

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29-48

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-8-48 to 8-29-48

and that I last saw him alive on 8-27-48

Immediate cause of death Adeno Carcinoma

of mouth

Due to with metastasis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. W. Bushnell

M. D. or other

Address

Date signed 8-29-48

RECEIVED
SEP 2 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08561

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:

County... Prince Georges
 City or town... Brandywine
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:
Croome Plaza, Shop Road

How long in hospital or institution?

3. (a) FULL NAME

John Webster Ferguson

4. Sex Male 5. Color or race Colored Widowed

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Florence Ferguson

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) February 3, 1883

8. AGE: Years Months Days If less than one day
65 - 6 21 hrs. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Clay Ferguson

13. Birthplace Maryland

14. Maiden name Bell Shapwell

15. Birthplace Maryland

16. Informant Wright Ferguson

Address Brandywine, Maryland

17. Burial Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 9, 1948

(month) (day) (year)

Cemetery or crematory St. Phillips Church Cem.

Location Agnews Md.

18. Funeral director Ritchie Bros.

Address Upper Marlboro, Md.

19. Date rec'd by registrar August 7, 1948 F. H. Bellingalee

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Brandywine

(If outside city or town limits, write RURAL and give nearest town)

Street No. Croome Plaza, Shop Road

(If rural, give LOCATION)

2.(a) If veteran, name war V.A.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1948 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death Acute congestive heart failure

Due to Cardiac vascular cerebral disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED
AUG 11 1948
BUREAU F. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08562

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:
County.....
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6. (b) Name of husband or wife	Howard Fisher
March 23, 1894	B. (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.)	11	11	11
---	----	----	----

8. AGE:	Years 54	Months 5	Days 1	If less than one day hrs. min.
---------	-------------	-------------	-----------	--------------------------------------

9. Birthplace	Calais, Northumberland, Va.
---------------	-----------------------------

10. Usual occupation	House wife
----------------------	------------

11. Industry or business	Sitterton Winstead
--------------------------	--------------------

MOTHER FATHER	12. Name	Colie, U.A.
	13. Birthplace	and milled Washington

	14. Maiden name	Hazel Greenwold
	15. Birthplace	Tyngsboro, U.S.A.

16. Informant	Robert Bush
Address	1101 Laurel Md.

17. Burial, cremation, or removal. Which?	Cemetery or crematory	Date thereof	8/24/48
---	-----------------------	--------------	---------

Location	Northumberland Corra
----------	----------------------

18. Funeral director	James T. Bryan, Inc.
Address	317 Penn Ave. D.C.

19. (Date rec'd by registrar)	Aug 24 1948 M. Brashears
-------------------------------	--------------------------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State	Va	County	Northumberland
-------	----	--------	----------------

City or town	Calais
--------------	--------

Street No.	(If rural, give LOCATION)
------------	---------------------------

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1948 at 6:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-15 1948 to 8/24 1948 and that I last saw her alive on 8/23 1948

Immediate cause of death Carcin Lung

Due to Cancer Brain

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. Howard

M. D. or other

Address Landmark Date signed Aug 24 1948

RECEIVED
AUG 26 1918
BUREAU V. S.

The correct age
is especially important. Physicians: please write the causes of death clearly and legibly
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08563

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County.

Prince George's
Riverdale, Md.

City or town.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 days

Hospital, institution, or street address where death occurred

Deland Memorial Hospital

How long in hospital or institution?

4 days

3. (a) FULL NAME

Mr. Henry Hailes

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband/wife

Joanna Hailes

7. Birth date of deceased (mo., day, yr.)

May. 27 1866

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

82 8 3 14 hrs. min.

9. Birthplace

North Carolina

(Town, county, and state)

10. Usual occupation

Government Machinist.

11. Industry or business

Retired

Solomon Hailes

12. Name

?

13. Birthplace

Jersey Wade

?

14. Maiden name

George A. Hailes (Hospital records)

Address 4902 Indian Lane, Berwyn Md.

Buried Date thereof 8/19/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Wash. D.C.

18. Funeral director NW Chambers Co.

Address 5801 Cleveland Ave

Aug 19 1948 James Seery

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Berwyn (If outside city or town limits, write RURAL and give nearest town)

Street No. 4900 Indian Lane (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 18 1948 at 11:28 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 14, 1948, to Aug 18, 1948

and that I last saw him alive on Aug 18, 1948

Immediate cause of death

Cerebral thrombosis

DURATION

4 days

Due to Hypertension

Unknown

Due to General arteriosclerosis

Unknown

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L.W. Maliss M.D. or other

Address Riverdale Med. Date signed 8-19-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08564

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges
City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs., 8 mos., 2 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 10 yrs., 8 mos., 2 days

3. (a) FULL NAME

CALLIE GARDNER

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Annulled

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1904

8. AGE:	Years	Months	Days	If less than one day
	44	4	25	hrs. min.

9. Birthplace..... 2 Tennessee

(Town, county, and state)

10. Usual occupation..... Housework

11. Industry or business.....

MOTHER FATHER	12. Name	Charles Gardner
---------------	----------	-----------------

MOTHER FATHER	13. Birthplace	? Tennessee
---------------	----------------	-------------

MOTHER FATHER	14. Maiden name	Della Rhea
---------------	-----------------	------------

MOTHER FATHER	15. Birthplace	? Tennessee
---------------	----------------	-------------

16. Informant..... Deceased

Address.....

17. removal (Burial, cremation, or removal. Which?) Date thereof..... Aug. 14, 1948

(month) (day) (year)

Cemetery or crematory.....

Location..... to Washington, D.C.

18. Funeral director..... Robert J. McGuire

Address..... 1820 - 9th St., N.W., Wash., D.C.

19. Aug. 14, 1948 Rawland S. Phillips

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2222 - 13th St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Aug. 13 1948 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 10 1937 to Aug. 13 1948
and that I last saw her alive on Aug. 13 1948

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

10 yrs
9 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

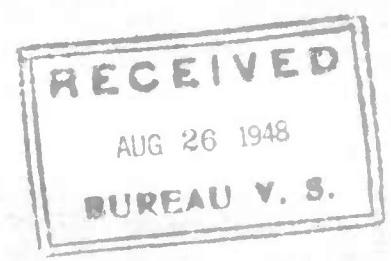
Means of injury..... Injured at work?

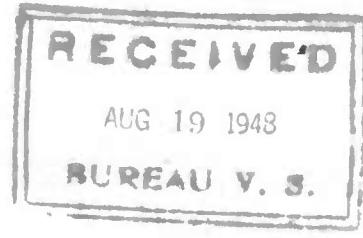
23. SIGNATURE..... Daniel P. Finucane M.D.

M. D. or other

8-13-48

Address..... Glenn Dale, Md., Date signed.....





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08568

1700

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH:

County... Prince George's

City or town... Cheverly, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 $\frac{1}{2}$ hours

Hospital, Institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution? 17 $\frac{1}{2}$ Hours

3. (a) FULL NAME

John Grund

John Grund

4. Sex _____ 5. Color or race _____ 6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife..... Mary Grund

Nee Leonard

6. (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) April 27, 1901

8. AGE: Years Months Days If less than one day
47 3 20 hrs. min.

9. Birthplace..... Laan, Estonia

(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Martell & Company

12. Name..... Madis Grund

13. Birthplace..... Estonia, Europe

14. Maiden name..... Wiu Jogi

15. Birthplace..... Estonia, Europe

16. Informant..... Mrs. John Grund

Address Marley Park, Glen Burnie, Md. P

17. Burial Date thereof..... August 19, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Glen Haven

Location..... Glen Burnie, Md.

18. Funeral director..... Thomas W. Singleton

Address..... Glen Burnie, Md.

19. 8/20th 48 Amanda L. [unclear] [unclear]
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Anne Arundel

City or town..... Marley Park, Glen Burnie, Md. P.O.
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Marley Neck Road.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death..... Intracranial hemorrhage

Due to..... Fractured skull & cerebral contusion.

Due to..... Automobile accident.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

O. 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Car accident Date of 8-16-48

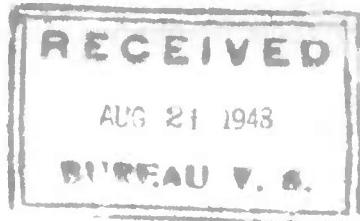
Where did injury occur? Near Collington P. S. Sea Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public highway

Means of injury..... Auto accident Injured at work? No

23. SIGNATURE..... John J. Maloney, Jr. M.D. or other

Address..... Cheverly, Maryland Date signed 8-17-48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08567

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges
 City or town..... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 19 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 3 mos., 19 days

3. (a) FULL NAME

HARDEN WILLIAM

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Negro

Married

6. (b) Name of husband or wife

Barbara Lee Harden

6. (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.)

November 15, 1915

8. AGE:

Years 32

Months 32

Days 8

If less than one day 28

hrs. min.

9. Birthplace.....

Nashville, Georgia

(Town, county, and state)

10. Usual occupation.....

Billing Attendant

11. Industry or business

- - -

12. Name.....

Will Harden

13. Birthplace

Ashville, North Carolina

14. Maiden name

Anna Mae Atkinson

15. Birthplace

Jacksonville, Florida

16. Informant.....

Deceased

Address

Removed to Wash D.C. Date thereof Aug 12, 1948
 (Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Location.....

Fraser Funeral Home Inc.

18. Funeral director.....

389-R Dale Ave.

Address

811 R Rowland S Phillips

19. (Date rec'd by registrar)

8/11 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2010 - 10th St. N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 12, 1948 at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/23, 1948 to 8/12, 1948

and that I last saw him alive on 8/12, 1948

Immediate cause of death

pulmonary tuberculosis

DURATION

6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Finucane M.D.

M. D. or other

Address

Glenn Dale, Md.

Date signed

8/12/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242

08566

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, Institution, or street address where death occurred:

none

How long in hospital or institution?

3. (a) FULL NAME

Magdalena Harich

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White Widowed

6.(b) Name of husband or wife

Philip Harich

Deceased

6.(c) If alive, give age

years

7. Birth date of deceased (m.o., day, yr.)

April 14 1882

8. AGE:

Years

Months

Days

If less than one day

66 - - hrs. min.

9. Birthplace

Yugoslavia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at Home

FATHER

12. Name

Carl Mattern

MOTHER

13. Name

Alma Echale

14. Maiden name

Alma Echale

15. Birthplace

Yugoslavia

16. Informant

Teresa Newton

Address

12059 St Hellade Rd

17. Burial

Cemetery or crematory

Cedar Hill

Location

Suitland Md

18. Funeral director

W.W. Chambers Co

Address

517 11th St S.E. DC

19. Date of death

1948

Date rec'd by registrar

Aug 25 1948

Carrie F. Campbell

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

County

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 24 1948 15th M

1948 1948 Aug 24 1948

and that I last saw her alive on Aug 26 1948

Immediate cause of death Bronchitis

Pneumonia

DURATION Aug 15 1948

Sudden

Zachman

Due to General Arteritis

Scleroderma

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide Date of

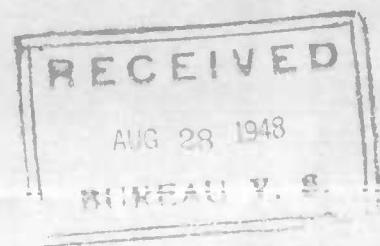
Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul C. Harich M. D. or other

Address Washington 1942 Date signed Aug 25 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

169

Reg. Dist. No. 231

08569

1. PLACE OF DEATH:
County..... Prince Georges
City or town..... Landover
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, Institution, or street address where death occurred:
Penn. R.R. Tracks

How long in hospital or institution?

3. (a) FULL NAME
Cecil Ford Hart

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced
Married

6.(b) Name of husband or wife..... Alice Elizabeth Hart

7. Birth date of deceased (mo., day, yr.) May 10, 1916
6.(c) If alive, give age..... 26 years

8. AGE: Years 32 Months 3 Days 19 If less than one day
hrs. min.

9. Birthplace..... Florida
(Town, county, and state)

10. Usual occupation..... Brakeman

11. Industry or business..... Penn. R.R.

MOTHER FATHER
12. Name..... Rubin Henry Hart
13. Birthplace

MOTHER
14. Maiden name..... Lillian Boyett
15. Birthplace

16. Informant..... Alice Elizabeth Hart
Address..... 1714 Bay St., S.E. Wash, D.C.

Burial
(Burial, cremation, or removal. Which?) Date thereof Aug 31, 1948
Cemetery or crematory Ft Lincoln

Location..... Colmar Manor Md.

18. Funeral director..... F. Goss & Sons
Address..... Hyattsville Md.

19. 8/31/48 Amanda Rooney
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D.C. County.....
City or town..... Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1714 Bay St., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 29 1948 at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... Complete decapitation and multiple compound fractures of body
Due to..... Being struck by train

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Accidental Date of 8-29-48

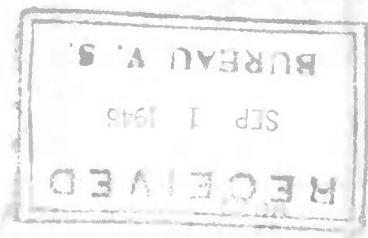
Where did injury occur?..... Landover Pr. Geo. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Railroad tracks

Means of injury Struck by train Injured at work? yes

23. SIGNATURE..... John J. Maloney, Esq.
M.D. or other

Address..... Cheverly, Md. Date signed 8-30-48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08570

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Bruce Georges
Cederville

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

male | 5. Color or race Colored

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.)

June 17, 1946

6. (c) If alive, give age..... years

8. AGE:

Years 22 Months 3 Days 11 less than one day

9. Birthplace.....

Washington DC

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

12. Name George W. Hawkins

13. Birthplace Washington DC

14. Maiden name Theresa Thompson

15. Birthplace Washington DC

16. Informant George W. Hawkins

Address Cederville, MD

17. Burial Date thereof 8-21-48

(Burial, cremation, or removal, which?)

Cemetery or crematory St. Peter's Cemetery

Location Maedow m d

18. Funeral director Harry L. Ryan

Address Maedow m d

19. Aug 21 1948 M. D. C. S. R. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Cederville (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1948 6:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death Bronchopneumonia DURATION

Measles

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of Injury

Slippery medical Examiner Injured at work?

23. SIGNATURE.....

M. D. or other

Address Hospitalized Date signed 8-20-48

RECEIVED
SEP 2 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFAILING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08571

CERTIFICATE OF DEATH

Reg. Dist. No. 242

181

1. PLACE OF DEATH:

County

City or town

Prince Georges
Brentwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

11 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sylvester Kinnard Hester

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Oct 11, 1947

8. AGE:

Years Months Days If less than one day

11

9

20

hrs.

min.

9. Birthplace

(Town, county, and state)

Washington D.C.

10. Usual occupation

11. Industry or business

Sylvester Hester

12. Name

North Carolina

13. Birthplace

Julia Boyd

14. Maiden name

North Carolina

15. Birthplace

Adeon Hester

16. Informant

Address 80 st Michaels st N.Y.C.

17. Burial

Date thereof August - '48

(Burial, cremation, or removal. Which?)

Month (day) (year)

Cemetery or crematory

Woodlawn Cemetery

Location

Washington D.C.

of F. Hester's Sons

18. Funeral director

Address Hyattsville, Md.

19. Date rec'd by registrar

8/2 1948

Amanda Downey

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Glenarden

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 1, 1948, at 4a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death

3rd degree burn of
entire body

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Glenarden, Prince George, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Home

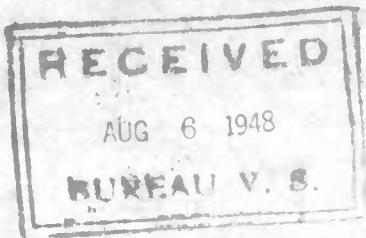
Means of injury Death by fire Injured at work?

23. SIGNATURE

John J. Maloney Esq.

M. D. or other

Cheverly, Maryland Date signed 8-2-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

08572

50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Col. widow

6. (b) Name of husband or wife

Lyfus Jackson

July 4-1882

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1945

8. AGE:

Years Months Days
66 If less than one day
hrs. min.

9. Birthplace

Va. (Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Joshua Murray

FATHER

12. Name

Va.

13. Birthplace

Everline Brooks

MOTHER

14. Maiden name

Va.

15. Birthplace

Thomas Carter

16. Informant

Fairfax Va.

Address

removal

Date thereof Aug 28 1948
(month) (day) (year)

Cemetery or crematory

Washington D.C.

Location

Henry S. Washington & Sons

18. Funeral director

467 N St. N.W. Wash. D.C.

Address

Aug 28 1948 James Berry

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

4511 - 4th and

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 27 1948 8:14 A.M.
Aug 23 1948 to Aug 27 1948
and that I last saw her alive on Aug 27 1948

Immediate cause of death

canceroma of left breast 4 yrs
Due to
canceroma of stomach 1 yr

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Date signed

Address 513-9th Laurel Hill



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08573

CERTIFICATE OF DEATH

Reg. Dist. No. 231

M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Prince George's

City or town Cheverly Md.

(If outside city or town limits, write RURAL and give nearest town)

4 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Prince George's Hosp

How long in hospital or institution?

4 days

3. (a) FULL NAME

Maxine W. James

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

John James

(If alive, give age) years

7. Birth date of deceased (mo., day, yr.)

July 17, 1911

8. AGE:

Years 37

Months

Days

If less than one day

hrs. min.

9. Birthplace

Bassett Illinois

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

E. T. Gardner

12. Name

Illinois

13. Birthplace

Grace Thompson Gray

14. Maiden name

Illinois

15. Birthplace

Husband - John James

16. Informant

Rivardale Md.

Address

Burial

Aug 9, 1948

Date thereof

(month) (day) (year)

(Burial, cremation, or removal Which?)

Cemetery or crematory

Location

Washington Ilc.

18. Funeral director

L. Gascot Sons

Address

Lyallville Ind.

19. Date rec'd by registrar

Aug 8, 1948

Amanda Doroney

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Prince

George

City or town

Rivardale

(If outside city or town limits, write RURAL and give nearest town)

Street No.

6116-

582

Av -

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

6 August 1948 at 3:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-2 1948 to

8-6 1948

and that I last saw her alive on

8-6 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

4 days

Due to: Rupture of Artery of Cerebrum
of Middle cerebral artery

4 days

Due to:

Other conditions: Cold & Bronchitis

2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: S. car.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

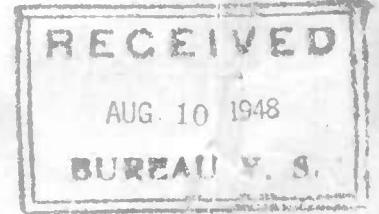
23. SIGNATURE

M. D. or other

Address

Mt. Rainier Md.

Date signed 8-7-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08591

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 6 mos., 29 days

Hospital, institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 6 mos., 29 days

3. (a) FULL NAME

JAMES RICHARD

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Negro Separated

6. (b) Name of husband or wife Elizabeth Williams

7. Birth date of deceased (mo., day, yr.) July 15, 1907

6. (c) If alive, give age 40 years

8. AGE: Years Months Days It less than one day

41 41 0 23 hrs. min.

9. Birthplace Florence, South Carolina

(Town, county, and state)

Laborer

10. Usual occupation.....

11. Industry or business ---

MOTHER FATHER 12. Name Chess James

13. Birthplace Florence, South Carolina

14. Maiden name Elvira Wilson

15. Birthplace Florence, South Carolina

Deceased

16. Informant.....

Address

17. Removal, cremation, or removal. Which? Date thereof Aug 9, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location Washington D.C.

18. Funeral director..... Jacob Brown

Address 2826 Eye St. N.W., Wash. D.C.

19. (Date rec'd by registrar) Aug 9 1948 Rowland S. Phillips

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 529 - 26th St., N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

225-05-4107

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1948 at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 8 1948, to Aug 7 1948, and that I last saw him alive on Aug 7 1948

Immediate cause of death.....

Pulmonary Tuberculosis

Duration 11 months

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Daniel Leo Pinuccio M.D.

M. D. or other

Address Glenn Dale, Md., Date signed 8/7/48

RECEIVED

AUG 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

134
8574

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 mos., 10 days

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution?..... 2 mos., 10 days

3. (a) FULL NAME

JOHNSON JOHN ALBERT

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Negro

Separated

6.(b) Name of husband or wife.....

Hattie Addison

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

May 10, 1889

8. AGE: Years

Months

Days

It less than one day

59

59

2

27

hrs.

min.

9. Birthplace.....

Howard Co., Maryland

(Town, county, and state)

10. Usual occupation.....

Truck Driver

11. Industry or business

MOTHER FATHER

12. Name..... William Thomas Johnson

? ?

13. Birthplace.....

Mary Fisher

14. Maiden name.....

? Maryland

15. Birthplace.....

16. Informant..... Deceased

Address

17. Burial Date thereof..... Aug 10 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Belair Cemetery

Location..... Baltimore, Md.

18. Funeral director..... Mrs. Kate A. Williams

Address..... 322 N. Schroyer St. Balt. Md.

19. (Date rec'd by registrar) 8/7/48 Rowland S. Phillips

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1631 Kramer St., N. E.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 6 1948 a.m. 5⁶⁰/m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/26 1948 to 8/6 1948

and that I last saw h. ieo alive on 8/6 1948

Immediate cause of death.....

pulmonary Interstitialis

DURATION

4 weeks

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

Daniel P. Finegan MD M. D. or other

Address..... Glenn Dale, Md. Date signed..... 8/6/58

RECEIVED

AUG 17 1948

BUREAU V. S.

~~M~~
PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08575

CERTIFICATE OF DEATH

66 b
Reg. Dist. No. 245

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 31 hours

Hospital, Institution, or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution?..... 31 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince Georges

City or town..... Berwyn

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Canary Trailer Camp- Lot 39

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

Bethel James Kemper

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife.....

Betty Kemper

7. Birth date of deceased (mo., day, yr.)

Feb. 10, 1906

6.(c) If alive, give age..... 38 years

8. AGE: Years

42

Months

6

Days

16

If less than one day

hrs.

min.

9. Birthplace.....

Kansas

(Town, county, and state)

10. Usual occupation.....

PIPE FITTER

11. Industry or business

MOTHER FATHER

Name..... Logan Edgar Kemper

13. Birthplace

Kentucky

14. Maiden name.....

Alice Elizabeth Sherrill

15. Birthplace

Kentucky

16. Informant.....

Leland Memorial Hosp. Records.

Address

Riverdale, Maryland

Transportation.....

Date thereof..... Aug 29, 1948
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory.....

Lombury Nebraska

Location.....

F. Gasch, Corp. -

18. Funeral director.....

Hyattsville Md

Address

Aug 29, 1948 James Derry

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 26

1948 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Acute Congestive Heart Failure

Due to..... Acute toxemia.

Due to..... Alcoholism

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

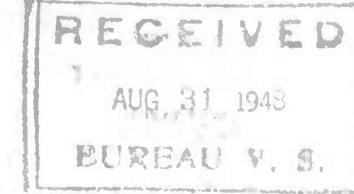
Injured at work?

23. SIGNATURE

John J. Malone, Esquire
Chesapeake - Md. Dep. Med.

M. D. or other

Address..... Date signed..... 8-27-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08576

CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH:

County Baltimore Co.City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maryland Hospital

How long in hospital or institution?

1 week

3. (a) FULL NAME

Margaret Kercheval

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

white

widowed

6. (b) Name of husband or wife

Edw. Merson

7. Birth date of deceased (mo., day, yr.)

Sep 16, 1878

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

69 11 4

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

12. Name

Lukens

13. Birthplace

14. Maiden name

Succie Merson

15. Birthplace

Baltimore City

16. Informant

Mrs. Edw. Merson

Address

Baltimore, Md.

17. Burial

Burial Aug 22, 48

(Burial, cremation, or removal. Which?)

(Date thereof) (month) (day) (year)

Cemetery or crematory

Hillside

Location

Baltimore

18. Funeral director

W. H. McDonald

Address

Baltimore, Md.

19. Date record by registrar

Aug 22, 1948 M. Brashears

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County BaltimoreCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

8 20 1948 at 6:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8 3 1948 to 8 20 1948and that I last saw her alive 8 20 1948

Immediate cause of death

Loose bowelsPneumoniaMyocardial failure2nd

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. P. Warren M. D. or otherAddress Baltimore, Md. Date signed 8 20 48X correct age
age

MARGIN RESERVED FOR BINDING

I

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; it is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED

AUG 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08577
245

Reg. Dist. No.

1. PLACE OF DEATH:

County Prince George

City or town Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 days

Hospital, institution, or street address where death occurred:

Eugene Heiland Memorial Hospital.

How long in hospital or institution? 41 days

3. (a) FULL NAME

Mrs. Mary M. Klein

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married.

6. (b) Name of husband or wife Mr Anton W. Klein
(Deceased)

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 9, 1874

8. AGE: Years Months Days If less than one day

73

9

19

hrs. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Mr. Ignatius Miller

13. Birthplace Washington, D.C.

14. Maiden name Mrs. Matilda Miller

15. Birthplace Washington, D.C.

16. Informant Mr. H. James Klein (Son)

Address 3809-10th St. N.W., Wash, D.C.

17. Burial Date thereof Aug 21, 1948
(Burial, cremation, or removal, which?)

Cemetery or crematory St. Mary's Cemetery

Location Washington, D.C.

18. Funeral director Francis J. Collins Funeral Home

Address 3821-14th St. N.W.

19. Aug 28, 1948 Mrs. Las Denee
(Date rec'd by Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D.C.

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 3809-10th St. N.W., Wash, D.C.
(if rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 20, 1948 at 4:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 18, 1948, to Aug 20, 1948
and that I last saw her alive on Aug. 20, 1948

Immediate cause of death

Cerebral hemorrhage
Due to arteriosclerotic heart disease

Due to

Other conditions diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

St. G. Schaffner, Jr. M.D. or other
4404 Greenbury Rd. Silver Spring, Md. Date signed Aug 28, 1948

RECEIVED

AUG 31 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0857.1

CERTIFICATE OF DEATH

Reg. Dist. No. 7

M
Margolin
The correct age

1. PLACE OF DEATH:

County.

Baltimore
Dr Georges

City or town.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

25 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Edgar Lloyd

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

W

W

Married

6. (b) Name of husband or wife

Mary Elizabeth Lloyd

8. (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

Aug 26, 1895

8. AGE:

Years
62Months
11Days
14If less than one day
hrs. min.

9. Birthplace

Maryland

10. Usual occupation

Farm hand

11. Industry or business

Lloyd

12. Name

Mother Father

Mary Lloyd

13. Birthplace

Maryland

14. Maiden name

E. Stanford

15. Birthplace

Maryland

16. Informant

John Lloyd

Address

1714 N. Post St., Balt. Md

17. Burial

Burial

(Burial, cremation, or removal, Which?)

Church of Ascension Cemetery

Cemetery or cemetery

Bowie Md

Location

F. Gash's son

18. Funeral director

H. Gash's son

Address

Hyattsville Md

19. Date rec'd by registrar

Aug 12 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

Maryland

County

City or town

Bowie

County

Street No.

Compton Road

County

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 10 1948*

at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....to.....19.....

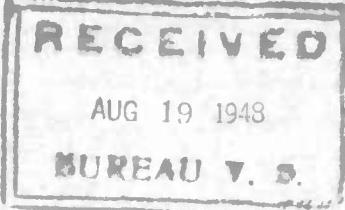
and that I last saw him alive on.....19.....

Immediate cause of death *Accidental**Amputation of right leg. Hemorrhage & shock*Due to *Horse drawn disc.*Due to Other conditions *Deep laceration &**penetrating of right thorax*
(Include pregnancy within 3 months of death)Major findings of operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident*Date of *8-10-48*here did injury occur? *Home and Dr. Geo.*(City or town) *(County) (State)*Injured at home, farm, industry, public place (where?) *Farm*Means of injury *Fell into disc.*Injured at work? *Yes*23. SIGNATURE *John J. Maloney, M.D.*M. D. or other Address *Cheverly - Hyattsville*Date signed *8-12-48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08528

CERTIFICATE OF DEATH

Reg. Dist. No. 345

1. PLACE OF DEATH:

County, Prince George

City or town, Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months

Hospital, Institution, or street address where death occurred:

4305-30th Street

How long in hospital or institution?

3. (a) FULL NAME

Clara Nettie Somp.

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Louis Somp.

7. Birth date of deceased (mo., day, yr.)

Dec 3, 1879

6. (c) If alive, give age 68 years

8. AGE:

Years

Months

Days

If less than one day

68 8 18

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Housewife

MOTHER FATHER

12. Name

Augustine Oberline

13. Birthplace

Unknown

14. Maiden name

Nettie Soper

15. Birthplace

Unknown

16. Informant

Mrs. Helen Copen

Address

4305-30th St., Mt. Rainier, Md.

17. Burial

Date thereof Aug 24, 1948

(Burial, cremation, or removal: Which?)

(Month) (day) (year)

Cemetery or crematory

Washington National

Location

Prince George County, Maryland

18. Funeral director

W. W. Chambers Co.

Address

5801-Cleveland Ave., Cleveland, Md.

19. Date rec'd by registrar

Aug 23 1948 James Derry

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State, Maryland

County, Prince George

City or town, Mt. Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4305-30th Street

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21

1948, at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

19...

and that I last saw him alive on

Immediate cause of death

Hypertensive Heart Disease

DURATION

4 yrs

Due to

Diabetes

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

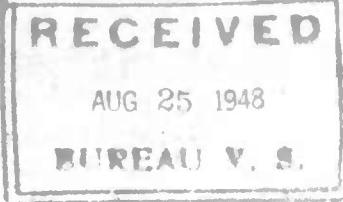
Injured at work?

23. SIGNATURE

John J. Maloney, Esq.

M. D. Doctor

Date signed 8-21-48



M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians especially important. Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47d

CERTIFICATE OF DEATH

Reg. Dist. No. 231

08560

1. PLACE OF DEATH:

County... Prince Georges

City or town... Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days 7 hours 45 min.

Hospital, institution, or street address where death occurred:

Prince Georges General Hospital

How long in hospital or institution? 12 days 7 hours 45 min.

3. (a) FULL NAME

Marcelle Mc Clure

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female w

married

6. (b) Name of husband or wife

Ray Mc Clure

7. Birth date of deceased (mo., day, yr.)

April 15, 1912

6. (c) If alive, give age..... years

8. AGE:

Years Months Days It less than one day

36 4 9 hrs. min.

9. Birthplace

Glenside, Penna.
(Town, county, and state)

10. Usual occupation...

Housewife

11. Industry or business

Louis W. Carroll

12. Name...

Louis W. Carroll

13. Birthplace

Wash. D. C.

14. Maiden name...

Anna V. Carroll

15. Birthplace

Portland, Maine

16. Informant...

Mr. Ray D. Mc Clure

Address

4016 Ingraham St. Mt Rainier Md.

17. Burial

Date thereof... 8/3/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Mt. Rainier

Location

Belvoir Manor Md

18. Funeral director

Martin W. Flynn Co.

Address

1300 N St NW

19. Date rec'd by registrar

1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State...

Maryland County... Prince Georges

City or town...

Mt Rainier

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4016 - Ingraham St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1948 at 9:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 1948 to Aug 24 1948

and that I last saw her alive on Aug 24 1948

Immediate cause of death

Sarcoma - Left Lung

Pt Leung in W.C.

Due to Cancer metastasis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed.....

H. G. Steele, Jr. 8-25-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08581

CERTIFICATE OF DEATH

157a
Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince George
City or town: Mt. Rainier Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos 5 days

Hospital, institution, or street address where death occurred:

Mrs. Bell's Nursing Home

How long in hospital or institution? 4 mos 3 days

3. (a) FULL NAME

Joyce Ann M. Cusin

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 1948

6. (c) If alive, give age years

8. AGE: Years 6 Months 7 Days 1 If less than one day hrs. min.

9. Birthplace: Arlington Hospital Va.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name of father: Ralph Henry M. Cusin

13. Birthplace: Wash. D.C.

14. Maiden name: Katherine Roger Boitch

15. Birthplace: Arlington Va.

16. Informant: Mrs. Everett Bell

Address: 3209 Perry St.

17. Removal Date thereof: Sept. 1-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location: Arlington, Va.

18. Funeral director: G. J. Clues

Address: 2847 Wilson Blvd. Arlington Va.

19. Date rec'd by registrar: Aug. 31 1948

Date signed: John J. Magoney

(Date rec'd by registrar) (Date signed)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Va. County:

City or town: Arlington Va.

(If outside city or town limits, write RURAL and give nearest town)

Street No: 616 N. Jefferson Va.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH: Aug. 31 1948 at 5:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Due to: Spina bifida

Due to: Severe hydrocephalus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

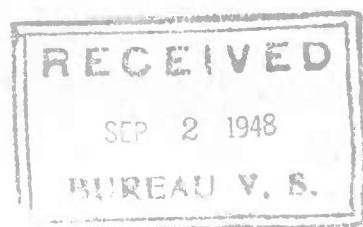
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John J. Magoney M. D. or other

Address: Cleverly- Md. Date signed:



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08582

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

Prince Georges

County

Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos., 22 days

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 3 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C.

County

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1315 Wallace Place, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Thomas M C McKinney

(McKinney)

3. (b) Social Security Number

- - -

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Negro

Married

6.(b) Name of husband or wife.....

Lillian McKinney (McKinney)

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.)

May 9, 1900

8. AGE: Years

Months

Days

If less than one day

48

48

2

24

hrs.

min.

9. Birthplace.....

Spartanburg, South Carolina

(Town, county, and state)

10. Usual occupation.....

Laborer

11. Industry or business

- - -

MOTHER FATHER

12. Name

John McKinney (McKinney)

13. Birthplace

Chesney, South Carolina

14. Maiden name.....

Ella Lwitty

15. Birthplace

Rutherford Co., North Carolina

16. Informant.....

Deceased

Address

17. Removal
(Burial, cremation, or removal. Which?)

Date thereof.....

Aug 4, 1948
(month) (day) (year)

Cemetery or crematory.....

Washington D.C.

Location.....

Washington D.C.

18. Funeral director.....

Address

J.W. Ernest Garay Co.
1432 30th St. NW

19. (Date rec'd by registrar)

8 - 4 1948 Rowland S. Phillips

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Aug 4 1948 at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/22 1948 to 8/4 1948

and that I last saw him alive on

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 1/2 days

Due to.....

Due to.....

Other conditions

Pulmonary Tuberculosis

6 yrs 2 mos

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

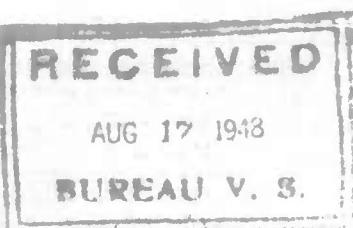
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Daniel Leo Finicane MD
M. D. or other
Glen Dale, Md Date signed 8/4/48



RECEIVED
AUG 17 1948
BUREAU V. S.

A faint, handwritten signature or message is written across the bottom of the stamp. The text appears to be "RECEIVED AUG 17 1948 BUREAU V. S." written in cursive script, which is partially obscured by the stamp's border.

PLEASE WRITE PLAINLY, WITH UNFADING INK.
Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08583

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs., 7 mos., 17 days

Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium

How long in hospital or institution? 6 yrs., 7 mos., 17 days

3. (a) FULL NAME

MIDDLETON LEA B

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Single

6.(b) Name of husband or wife: -

7. Birth date of deceased (mo., day, yr.)

July 19, 1878

6.(c) If alive, give age - years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Washington, D. C.

(Town, county, and state)

10. Usual occupation.....

Patent Attorney

11. Industry or business: - - -

MOTHER FATHER

12. Name..... Lea B. Middleton

13. Birthplace.....

Washington, D. C.

14. Maiden name.....

Anne Dort

15. Birthplace.....

Washington, D. C.

16. Informant.....

Deceased

Address

17. Burial..... Removal

Date thereof.....

Aug 17-1948
(month) (day) (year)

Cemetery or crematory.....

Location.....

Washington, D. C.

18. Funeral director.....

Address.....

Debel Funeral Home
4812 Leiley P. Wach, D. C.

19. Date rec'd by registrar.....

Aug 17, 1948

Rowland S. Phillips

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C.

County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1301 Vermont Avenue, N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3. (b) Social Security Number

579-10-2114

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Aug 17-1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18/30 1941 to 8/17 1948

and that I last saw him alive on 8/17 1948

Immediate cause of death.....

Pulmonary tuberculosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

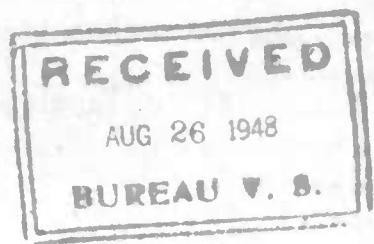
Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Glenn Dale, Md. Date signed 8/17/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 50
745

1. PLACE OF DEATH: PRINCE Georges
County.....
City or town..... COLLEGE PARK, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, Institution, or street address where death occurred: COLLEGE PARK
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Md .. County..... Prince Georges
City or town..... COLLEGE PARK, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

3. (a) FULL NAME ESTHER WEBB MOWATT

3. (b) Social Security Number _____

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced					
FEMALE	White	MARRIED					
6. (b) Name of husband ex-wife		ALEXANDER MOWATT					
7. Birth date of deceased (mo., day, yr.)	6. (c) If alive, give age 68 years						
FEB 26 - 1882							
8. AGE:	Years 66	Months 5	Days 25	If less than one day	hrs.	min.	
9. Birthplace	OXFORD, ENGLAND (Town, county, and state)						
10. Usual occupation	Housewife						
11. Industry or business	—						
MOTHER FATHER	12. Name	WILLIAM WEBB					
	13. Birthplace	OXFORD, ENGLAND					
	14. Maiden name	HARRIET WHITE					
	15. Birthplace	OXFORD, ENGLAND					
16. Informant	MRS. MAJORIE SHIRK						
Address	College Park, Md						
17. Burial	Date thereof	Aug. 23, 1948					
(Burial, cremation, or removal. Which?)	(month)	(day)	(year)				
Cemetery or crematory	St. John Church Cemetery						
Location	Beltsville, Md						
18. Funeral director	T. Jackie Sonc						
Address	Synthesia 2nd						
19. Date rec'd by registrar	Aug. 22 1948 Mrs. Joe Severe						
(Date rec'd by registrar)	Wife of Local Registrar						

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 August 1948 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 July 1948 to 20 Aug 1948 and that I last saw her alive on 20 Aug 1948.

Immediate cause of death Bilateral Pulmon ary Congestion DURATION

Due to METASTATIC CARCINOMA OF LUNGS - BILATERAL 2 yrs

Due to CARCINOMA OF LEFT BREAST 1943

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

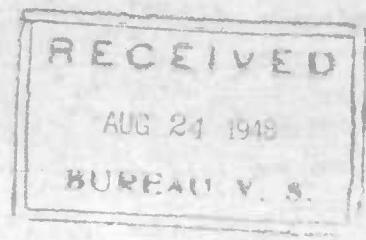
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. E. J. Egan M. D. on other

Date signed 8-21-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08585

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges
 City or town Fairmont Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

JOHN THOMAS PALMER

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MC

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 1883

6. (c) If alive, give age..... years

8. AGE:

Years
65

Months

Days

If less than one day

.... hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name ROBERT H. PALMER

13. Birthplace

MD

MOTHER

14. Maiden name YANNAH CARROLL

15. Birthplace

MD

16. Informant

Robert H. Palmer Brother

Address

718-58" Ave.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 21/48

Cemetery or crematory

Lincoln Mem Cemetery

Location

Washington D.C.

18. Funeral director

Barnes & Matthews

Address

614-4" St. S.W. Wash, D.C.

19. Date rec'd by registrar

Aug. 19 1948Carrie F. Campbell

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State DC CountyCity or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2730 - Sherman Ave NW

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 19 1948 at 2:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 3 1948 to Aug. 19 1948and that I last saw him alive on Aug. 18, 1948 1948Immediate cause of death Cerebral hemorrhagestrokeDue to Chronic Hypertension

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results non

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

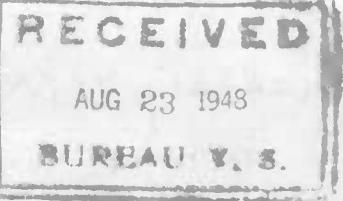
Means of injury

Injured at work?

23. SIGNATURE

Vernon A. Wilherson M. D. or otherAddress 61 K St NW Date signed Aug 19 1948

Wash DC



M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08580

CERTIFICATE OF DEATH

Reg. Dist. No.

2465

1. PLACE OF DEATH:

Prince Georges

County.....

Brentwood, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Harry Charles Peltier

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

married

6.(b) Name of husband or wife

Eva Peltier

6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.)

Oct 17, 1892

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

New York

(Town, county, and state)

10. Usual occupation

Guard

11. Industry or business

MOTHER FATHER

Eugene Peltier

New York

13. Birthplace

Unknown

14. Maiden name

New York ?

15. Birthplace

Eva Peltier

16. Informant

brentwood, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug 23, 1948

(month) (day) (year)

Cemetery or crematory

Arlington, In.

Location

Colma, Virginia and

18. Funeral director

F. Gasch's Sons

Address

Hyattsville, Md.

19. Date rec'd by registrar

Aug 23

1948

James Davis

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Prince Georges

Brentwood

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4529

34th St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-20 1948 about

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8-16 1948 to 8-20 1948

and that I last saw him alive on 8-19 1948

Immediate cause of death

Acute Cardiac Palitation
(Pain during sleep)Due to Chronic Myocarditis
& Congestive Failure

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

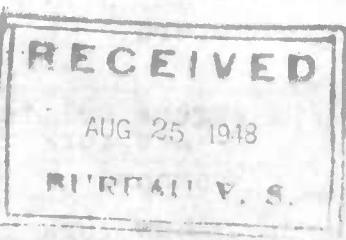
23. SIGNATURE

H. H. Peltier M.D.

M. D. or other

Address

Mt. Rainier Md. Date signed 8-20-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08587

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County. Prince Georges.

City or town. Hyattsville Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Myrtle Elizabeth Pierson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female white married

6. (b) Name of husband or wife Charles J. Pierson

6. (c) If alive, give age 82 years

7. Birth date of deceased (mo. day. yr.) Feb 2, 1879

8. AGE: Years Months Days If less than one day
69 hrs. min.

9. Birthplace Pa (Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Andrew Never

13. Birthplace Pa

14. Maiden name Margaret Never

15. Birthplace Pa

16. Informant Miss Bernice F. Pierson

Address Hyattsville Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Aug 20, 1948

Cemetery or crematory Cedar Hill Cemetery

Location Suitland Maryland

18. Funeral director F. Gasch's Sons

Address Hyattsville Maryland.

Aug 30 (Date rec'd by registrar)

19. Jane Berry

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Hyattsville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4918 43 avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 Aug 1948 at 9 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jane 1942 to 19 Aug 1948 and that I last saw her alive on 18 Aug 1948

Immediate cause of death acute delation and myocardial infarction

Due to terminal complication of acute diarrhea and enteritis

Due to pneumonia which she seemed to be recovering

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

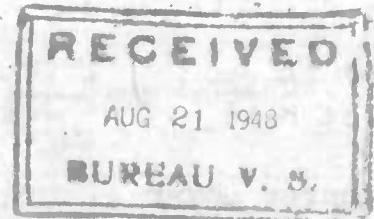
Means of injury

Injured at work?

23. SIGNATURE

Jane Berry M.D. M. D. or other

Address 2200 R. 9 ac ME 18 Dt Date signed 20 Aug 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete or illegible answers will not be corrected.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08588

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:

County..... Prince Georges

City or town..... Glenn Dale, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos., 6 days

Hospital, Institution, or street address where death occurred:

Glenn Dale Sanatorium

How long in hospital or institution? 7 mos., 6 days

3. (a) FULL NAME

ARTHUR H. QUINN

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Sarah L. Quinn

7. Birth date of deceased (mo., day, yr.)

September 8, 1912

6. (c) If alive, give age

37

years

8. AGE:

Years
35Months
35Days
11

If less than one day

hrs. min.

9. Birthplace

Richmond, Virginia

(Town, county, and state)

10. Usual occupation

Iron Worker

11. Industry or business

James Leroy Quinn

12. Name

Atlanta, Georgia

13. Birthplace

Viola Hypes

14. Maiden name

? Virginia

15. Birthplace

16. Informant

Deceased

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug. 21, 1948

(month) (day) (year)

Cemetery or crematory

Fort Lincoln Cemetery

Location

Prince George's County, Md.

18. Funeral director

J.W. Lee Sons Co.

Address

300-4 28. N.E. Wash D.C.

19. Date rec'd by registrar

Aug. 19, 1948 Rowland S. Phillips

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 3126 E. Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

227-09-3078

MEDICAL CERTIFICATION

20. DATE OF DEATH

AUG. 19 1948 at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JAN. 12 1948 to AUG. 19 1948

and that I last saw him alive on AUG. 19 1948

Immediate cause of death

Tuberculous Meningitis

DURATION

3 mo.

Date of

Paroxysmal Tuberculosis

8 mo.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

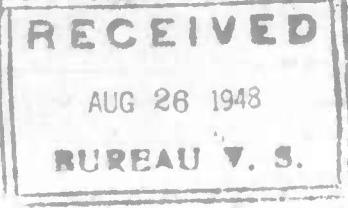
Injured at work?

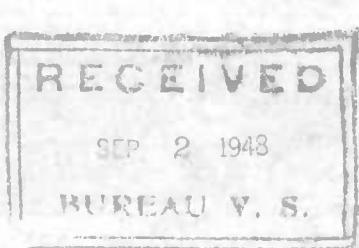
23. SIGNATURE

M. D. or other

Address

Glenn Dale, Md. Date signed 8-19-48





I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1639
145

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH:

County... Prince Georges
City or town... Riverdale, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 minutes

Hospital, institution, or street address where death occurred:
Seland Memorial Hospital

How long in hospital or institution? 40 minutes

2. (a) FULL NAME

John Stephens Reynolds

4. Sex

m w. Married

5. Color of race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Clara B. Reynolds

6. (c) If alive, give age... 55 years

7. Birth date of deceased (mo., day, yr.)

June 30, 1896

8. AGE:

Years	Months	Days	If less than one day,
52	1	19	hrs. min.

9. Birthplace

Baltimore, Md.

(town, county, and state)

10. Usual occupation

Electrician

11. Industry or business

Thomas Reynolds

Balt. Md.

12. Name

Thomas Reynolds

13. Birthplace

Balt. Md.

14. Maiden name

Sarah V. Stevens

15. Birthplace

Balt. Md.

16. Informant

Clara D. Reynolds

Address

5413 - Rivendale Rd. Rivendale

17. Burial

Date thereof Aug. 23, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Arlington National Cemetery

Location

Day

18. Funeral director

F. Gasch's Sons

Address

Glynnville, Md.

19. (Date rec'd by registrar)

Aug. 22, 1948

Mrs. Jas. Severe

Deputy Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince Georges

City or town... Riverdale (If outside city or town limits, write RURAL and give nearest town)

Street No. 5413 - Rivendale Road (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1948 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on

Immediate cause of death

Suicide by drink-
ing poison

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

Some

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of Aug. 19, 1948

Where did Injury occur? Rivendale, Pa. Sea - Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

home

Means of Injury Suicide

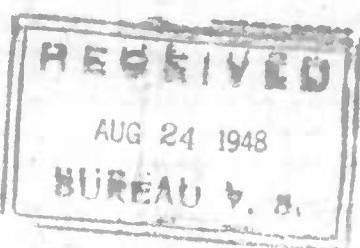
Injured at work?

23. SIGNATURE

John J. Maloney, M.D. Examiner Deputy

M. D. or other

Address... Chevy Chase, Md. Date signed Aug. 19, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08592

CERTIFICATE OF DEATH

94a
Reg. Dist. No. 237

1. PLACE OF DEATH:

County. Prince George's
Ritchie

City or town. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years.

Hospital, institution, or street address where death occurred:

6767 Whitehouse Rd.

How long in hospital or institution?

3. (a) FULL NAME

Arthur Pinkney Ryon

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

(Nee Reed)

Edith Ryon

6. (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.)

July 5, 1883

8. AGE:

Years
65Months
1Days
16

If less than one day

hrs. min.

9. Birthplace Prince Georges Co., Md.

(Town, county, and state)

10. Usual occupation Retired Clerk

11. Industry or business

12. Name William S. Ryon

13. Birthplace Prince Georges Co., Md.

14. Maiden name Christiana Wilson

15. Birthplace Prince Georges Co., Md.

16. Informant Mrs. Edith Ryon (Wife)

Address 6767 Whitehouse Rd., Washington, D.C.

17. Burial Cemetery or crematory Cedar Hill

Date thereof Aug. 24, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Location Suitland, Maryland

18. Funeral director Ritchie Bros.

Address Upper Marlboro, Md.

19. Date rec'd by registrar Aug. 23, 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Prince Georges

City or town Ritchie

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6767 Whitehouse Rd.

(If rural, give LOCATION)

No

2.(a) If veteran, name war

3. (b) Social Security Number

No

MEDICAL CERTIFICATION

20. DATE OF DEATH Sat. August 21, 1948, at 8:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 6, 1948, to Aug 21, 1948
and that I last saw him alive on Aug 21, 1948

Immediate cause of death

Coronary Thrombosis

DURATION

± Year

Due to

Arteriosclerosis

2020

Due to

Hypertension

10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Upper Marlboro, Md. Date signed Aug 23, 1948

RECEIVED

AUG 24 1948

BUREAU V. B.

~~M~~
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08593

FILM NO. G 117 SEP -2 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:

County... Prince George's
City or town... Cheverly
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days 3 hrs. 10 min.

Hospital, Institution, or street address where death occurred:

Prince George's General Hospital

How long in hospital or institution?

3. (a) FULL NAME

MRS. Lewis Blanche Schmidt

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

w

married

6. (b) Name of husband or wife Walter A. Schmidt

6. (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.)

Sept. 24 1909

8. AGE: Years

Months

Days

If less than one day

38 39

2

hrs.

min.

9. Birthplace

Colorado
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

Harry M. Wiley

12. Name

Mother FATHER

13. Birthplace

Zanna Lewis

14. Maiden name

Pa

15. Birthplace

a. walter schmidt

16. Informant

Cheverly Md. -

transportation

(Burial, cremation, or removal. Which?)

Date thereof Aug 29, 1948

(Month) (day) (year)

Cemetery or crematory

Seneca

Location

Colorado

Z. Grack's sons

Hyattsville Md.

Address

Aug 29 1948

Amanda D. O'Dorney

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince George's

City or town... Cheverly
(If outside city or town limits, write RURAL and give nearest town)Street No. 2407-59th Place
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

8/26 1948 at 6 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 1948 to August 1948

and that I last saw her alive on 8/26 1948

Immediate cause of death Septicemia

DURATION

Due to Primary inertia & ruptured
membraneDue to Pregnancy - Placenta
Previa

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations Extra. peritoneal hemorrhage
Sectomy: cesarean, abn. date of op. 6/26/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

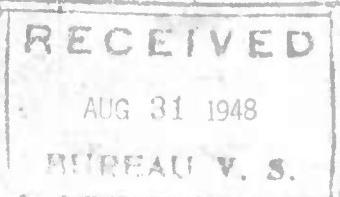
Injured at work?

23. SIGNATURE

Frank Warren, M.D.

M. D. or other

Address 1746 K St. N.W. Date signed 8/26/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08594

CERTIFICATE OF DEATH

Reg. Dist. No. 830

245

1. PLACE OF DEATH:

Prince Georges

County

Riverdale

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs, 8 months

Hospital, institution, or street address where death occurred:

Eugene Leland Memorial Hospital

How long in hospital or institution? 5 yrs, 8 months

3. (a) FULL NAME

Scott, Mrs. Iana

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

white

Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 21, 1862

8. AGE:

Year

Months

Days

If less than one day

86

5

10

hrs.

min.

9. Birthplace

Washington, D. C.

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

—

12. Name

Jerimiah Indermauer

MOTHER FATHER

13. Name

Washington, D. C.

14. Maiden name

Margaret Ann Normis

15. Birthplace

Washington, D. C.

16. Informant

Hospital records

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept 3, 1948

(month) (day) (year)

Cemetery or crematory Congressional Cemetery

Location Washington, D. C.

18. Funeral director

Wm Lee's Sons Co.

Addressee 3 as 7th St. N.E.

19. Aug 31, 1948

(Date rec'd by registrar)

Mrs. J. Severe

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Prince Georges

City or town Berwyn

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 31,

1948 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1942 19, to Aug 31 1948

and that I last saw her alive on Aug 31

1948

Immediate cause of death

Cerebral hemorrhage / wed

Due to General arterosclerosis 10 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. W. Martin M.D.

M. D. or other

Address Riverdale, Md.

Date signed 8-31-48

RECEIVED

SEP 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 7-32

1. PLACE OF DEATH:

County

City or town

Rural - Mitchellville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 d

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charity Matilda Shepherd

4. Sex

F Col married

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Thomas Shepherd

7. Birth date of deceased (mo., day, yr.)

April 15 1874

6. (c) If alive, give age 82 years

8. AGE:

Years Months Days If less than one day

74 3 4 hrs. min.

9. Birthplace

Mitchellville, P. S. Co. Md.

(Town, county, and state)

10. Usual occupation

Dairymaid

11. Industry or business

Estate Mitchell

FATHER

12. Name

Mitchellville, Md.

13. Birthplace

Henrietta Fletcher

14. Maiden name

Mitchellville, Md.

15. Birthplace

Thomas Shepherd

16. Informant

Thomas Shepherd

Address

Mitchellville, Md.

17. Burial

Date thereof April 23 1948
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Holy Lamb Cemetery

Location Hornsway Rd.

Funeral director George Rogers

Address Mitchellville, Md.

19. Aug 20 1948

(Date recd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md County

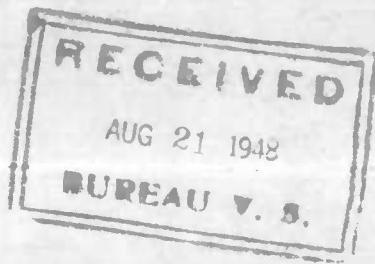
City or town

Rural - Mitchellville

Street No.

1 mi east of Mitchellville

(If outside city or town limits, write RURAL and give nearest town)



~~1~~ ~~the correct age~~
NAME, addr: STATEMENT
FROM INFORMANT authorizing
changes. Filmed G117 8-30-48.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08596

CERTIFICATE OF DEATH

83a
Reg. Dist. No. 231

1. PLACE OF DEATH:

County.....

City or town.....

Prince George's
Cheverly

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

6 hours

Hospital, Institution, or street address where death occurred:

Prince George's Hosp

How long in hospital or institution?.....

6 hours

3. (a) FULL NAME

Benjamin Robert Sherwood - wife

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.....

Nettie Sherwood

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

January 24, 1879

8. AGE: Years

69

Months

6

Days

29

If less than one day

hrs.

min.

9. Birthplace.....

Falls Church Virginia

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

W.S. Government

MOTHER FATHER

12. Name.....

Robert J. Sherwood (ROBERT J. A.)

13. Birthplace.....

Va

14. Maiden name.....

Mary Virginia Mills

15. Birthplace.....

FAIRFAX VIRGINIA

16. Informant.....

Robert Sherwood

Address

4014-31st St. Mt. Rainier, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Aug 24, 1948
(month) (day) (year)

Cemetery or crematory.....

St. Lincoln Cemetery

Location.....

Colmar Manor, Md.

18. Funeral director.....

J. Grada Son

Address

Hyattsville, Md.

19. Date rec'd by registrar

Aug 22, 1948 Mrs. Jas. Severe

(Date rec'd by registrar)

Deputy Supt. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Prince George

City or town.....

Mt. Rainier

Street No.....

4006

- 31st

Street

(If outside city or town limits, write RURAL and give nearest town)

31

Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21 July August 1948 at 8:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, pub'l'c place (where?).....

Means of injury.....

Injured at work?

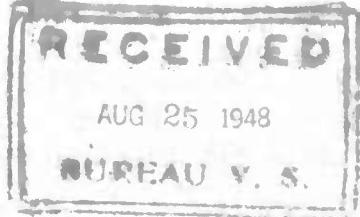
23. SIGNATURE.....

John J. Maloney, Examiner
Deputy Supt. Registrar
Cheverly, Md.

M. D. or other

8-21-48

Date signed.....



RECEIVED
AUG 19 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITHOUT FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08598
244

17/a

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH:

County Prince George
 City or town Riverdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 minutesHospital, institution, or street address where death occurred:
Belair Memorial HospitalHow long in hospital or institution? 15 minutes

3. (a) FULL NAME

George Stewart Skinner

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Mable Irene Skinner

7. Birth date of deceased (mo., day, yr.)

April 15, 18946. (c) If alive, give age 36 years

8. AGE:

Years <u>54</u>	Months <u>4</u>	Days <u>13</u>	If less than one day
-----------------	-----------------	----------------	----------------------

9. Birthplace

Madison, Va
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Construction

12. Name

Charles Edward Skinner

13. Birthplace

Newport News, Va.

14. Maiden name

Laura Adams

15. Birthplace

Allegany County, Va

16. Informant

Hazel Mae Thompson

Address

M. Arthur Bowditch, Box 25
Bureau

(Burial, cremation, or removal. Watch?)

Cemetery or crematory

Location

17. Date thereof

(month day year)

Cause of death

Date

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)Street No. 4309-30th St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1948 at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h alive on 19.

Immediate cause of death Fracture of clavicle (81)
Fracture of 1st, 2nd & 3rd ribs (Rt.)
Laceration of 1st portion of esophagus
Bleeding Anemia Hemorrhage
& shock

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental Date of 8-28-48Where did injury occur? Brentwood (City or town) Pr. Geo. Md (County) (State)Injured at home, farm, industry, public place (where?) BrentwoodMeans of injury struck by trolley Injured at work?

23. SIGNATURE

John J. Maloney, M.D.

M. D. or other

Address Chesapeake, Md Date signed 8-29-48

RECEIVED
SEP 2 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08599

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County... Prince Georges
City or town... Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

403 Belford Place

How long in hospital or institution?

3. (a) FULL NAME

Florence M. Sloan

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ginson Merrick Sloan

7. Birth date of deceased (mo., day, yr.)

Sept 7, 1906

6. (c) If alive, give age 79 years

8. AGE:

Years 41

Months 11

Days 27

It less than one day
hrs. min.

9. Birthplace

Philadelphia, Pa.

(Town, county, and state)

10. Usual occupation

House-wife

11. Industry or business

Louis M. Sloan

MOTHER FATHER

12. Name

Louis M. Sloan

13. Birthplace

Sykesville

14. Maiden name

Florence Harper

15. Birthplace

Philadelphia

16. Informant

Ginson Merrick Sloan

Address

403 Belford Place

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof 3 Sept 1948

(month) (day) (year)

Cemetery or crematory

In Funeral Home

Location

Washington, D.C.

18. Funeral director

J. J. Jacobs - Sons

Address

Hyattsville Md.

19. Sept 3, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Prince Georges

City or town... Takoma Park (If outside city or town limits, write RURAL and give nearest town)

Street No... 403 - Belford Place (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1948

at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Cerebral Compression

Due to Subdural Hemorrhage

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of 8-31-48

Where did injury occur? Takoma Park, Prince Georges, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury

Injured at work?

23. SIGNATURE

John J. Maloney, M.D. Esq. Deputy

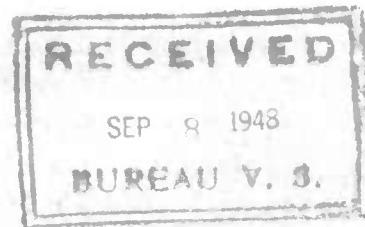
M. D. or other

Address Cheverly, Hyattsville Date signed 9-1-48

PL 2000

permitted

Modo



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County.....

City or town.....

Prince Georges

Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3 years

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

Gertrude E. Stalcups

7. Birth date of deceased (mo., day, yr.)

Oct. 31, 1878

6. (e) If alive, give age 66 years

8. AGE:

Years

Months

Days

If less than one day

69

.hrs.

min.

9. Birthplace.....

Norton, Kansas

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

Clerk

MOTHER

FATHER

12. Name.....

Walter Jones Stalcups

13. Birthplace.....

Unknown

14. Maiden name.....

Mary Elizabeth Gason

15. Birthplace.....

Unknown

16. Informant.....

Ulysses Stalcups

Address

4103 - Longfellow St. Hyattsville

17. Burial

Date thereof Aug. 27, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Fort Lincoln Cemetery

Location.....

3201-Bldngs Bldg. Colmar Manor

18. Funeral director.....

William J. Nalley

Address

3200 - R. I. Ave. Mt. Rainier, Md.

19. Date rec'd by registrar

Aug. 27, 1948 James Berry

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

Hyattsville (If outside city or town limits, write RURAL and give nearest town)

Street No.....

4103 - Longfellow

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

8-24

1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 1, 1948, to Aug. 21, 1948,

and that I last saw him alive on Aug. 24, 1948

Immediate cause of death.....

Carcinoma of
Prostate.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injury at home, farm, industry, public place (where?)

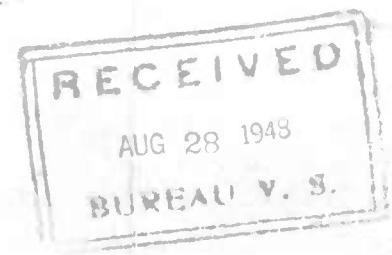
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08601

CERTIFICATE OF DEATH

462
Reg. Dist. No. 732

1. PLACE OF DEATH:

County... Baltimore
City or town... Allentown (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yr

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? 2 weeks

3. (a) FULL NAME

Harvey Maurice N. Stockman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m w married6. (b) Name of husband or wife Annie M. Stockman7. Birth date of deceased (m., day, yr.) June 25 18878. AGE: Years 64 Months Days If less than one day hrs. min. 9. Birthplace Fredrick Co Maryland (Town, county, and state)10. Usual occupation Farmer Retired11. Industry or business Own Farm12. Name Harold Maurice Cyprian Stockman13. Birthplace Maryland14. Maiden name Annie Lippins15. Birthplace Maryland16. Informant Annie M. StockmanAddress 7225 Allentown Rd SE17. BURIAL. (Burial, cremation, or removal. Which?) Date thereof 8-26-48

(month) (day) (year)

Cemetery or crematory Lutheran CemeteryLocation Allentown18. Funeral director BlanchillAddress Middleton, Md.19. Date rec'd by registrar Aug 25 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George CoCity or town Allentown Road - DC 20 (If outside city or town limits, write RURAL and give nearest town)Street No. 7225 Allentown Road - (If rural, give LOCATION)2.(a) If veteran, name war none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 20 1948 to Aug 23 1948and that I last saw him alive on Aug 23 1948

Immediate cause of death

Carcinoma of Transverse colon with metastases to liver and glands

DURATION

3 months

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations Carcinoma of Transverse colon as above Date of op. July 20 1948

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

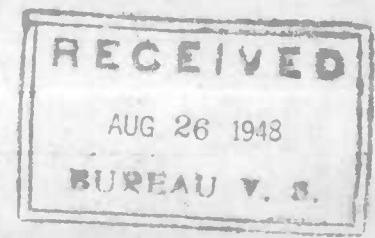
Accident, suicide, or homicide Malicious Curiosity Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul O'Brien Yatto M. D. or otherAddress Washington 19 DC Date signed Aug 23 1948



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08602

CERTIFICATE OF DEATH

Reg. Dist. No. 245

93d

1. PLACE OF DEATH:

County

Prince Georges County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 years

Hospital, institution, or street address where death occurred:

4605-Baltimore Road

How long in hospital or institution?

3. (a) FULL NAME

Mary Agnes Sullivan

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

W.

Widowed

6. (b) Name of husband or wife

John A. Sullivan

7. Birth date of deceased (mo., day, yr.)

May 8, 1873

6. (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
75	3	3	hrs. min.

9. Birthplace

Ireland

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Conway

MOTHER FATHER

12. Name	Conway
13. Birthplace	Ireland

14. Maiden name

Mary Flynn

15. Birthplace

Ireland

16. Informant

John J. Sullivan

Address

4605-Baltimore Rd., Hyattsville

Burial

Aug 13, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Mt. Olivet

Location

Washington D.C.

18. Funeral director

L. Gossel Sons

Address

Hyattsville Md

19. Date rec'd by registrar

Aug 13, 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Prince Georges

City or town

Hyattsville (If outside city or town limits, write RURAL and give nearest town)

Street No.

4605-Baltimore Road. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1948, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

My pernicious heart disease with decompensation

Due to

Due to

Other conditions

Pneumonia due to multiple embolistic throbs
(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

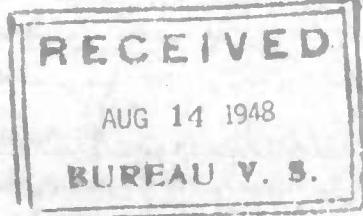
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Maloney, M.D.

N. D. or other

Address Cheverly-Hyattsville Date signed 8-11-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08603
1312

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County... Prince Georges

City or town... Cedar Hts.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Walter Alexander Thomas

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

Colored Married

6. (b) Name of husband - wife

Anner Lou

6. (c) If alive, give age 70 years

7. Birth date of deceased (mo. day. yr.)

Feb 13, 1878

8. AGE:

Years 70

Months 6

Days 16

If less than one day

hrs. min.

9. Birthplace

Stanton, Virginia

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name JACK THOMAS

13. Birthplace Stanton, Virginia

14. Maiden name Maggie Fitzgerald

15. Birthplace Stanton, Virginia

16. Informant

Anner Thomas

Address

1028-65 Avenue

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Sept 1, 1948

(month) (day) (year)

Cemetery or crematory

Woodlawn Cemetery Washington, D.C.

Location

John J. Blighes

18. Funeral director

John J. Blighes

Address

901-3rd St SW

19. Sept 1, 1948

(Date rec'd by registrar)

Edna F. Tolson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Cedar Hts.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1028-65 Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1948, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1st 1947 to Aug 29, 1948 and that I last saw him alive on Aug 27, 1948.

Immediate cause of death

Coronary Thrombosis

DURATION

2 hrs

Due to

Coronary Sclerosis

?

Due to

Nephrosclerosis

?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

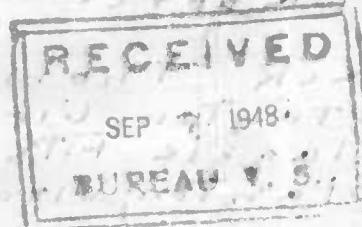
Injured at work?

23. SIGNATURE

Wilbur F. Jackson M.D. or other

Address 319-Division Ave, N.E. Date signed 8/29/48

Washington, D.C.



1. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08604

CERTIFICATE OF DEATH

Reg. Dist. No. 231

137a

1. PLACE OF DEATH:

County: Prince George
City or town: Cheverly, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death:

Hospital, Institution, or street address where death occurred:

Dr. Geo. Gen. Hospital

How long in hospital or institution? 4 weeks.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Olneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 90

(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3. (a) FULL NAME

Thomas Henry Lydings

3. (b) Social Security Number

No.

4. Sex: Male Color or race: White

5. (a) Single, married, widowed, or divorced: Widower

6. (b) Name of husband or wife: Sarah Rebecca Lydings

7. Birth date of deceased (mo., day, yr.): Jan. 30, 1870

B. (c) If alive, give age: years

8. AGE: Years: 78 Months: 6 Days: 16 It less than one day: hrs. min.

9. Birthplace: Upper Marlboro, Md.

(Town, county, and state)

10. Usual occupation: retired

11. Industry or business:

12. Name: T. Lydings

13. Birthplace: Md.

14. Maiden name: don't know

15. Birthplace: don't know

16. Informant: Mr. Emily Hook

Address: Croom Station, Md.

17. Burial: Date thereof: 8/19/48

(Burial, cremation, or removal. Which month) (day) (year)

Cemetery or crematory: St. Peter's Cemetery of the Fields

Location: Millersville Anne Arundel Co. Md.

18. Funeral director: Hattie Bros.

Address: Upper Marlboro, Md.

19. (Date rec'd by registrar): August 16 1948

O'Donnell, Amanda D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 16 1948 at _____

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 18 1948 to Aug. 16 1948

and that I last saw him alive on Aug. 14 1948

Immediate cause of death: Pulmonary Embolus

Due to: Post op Complication

Due to: Prostatectomy

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Hypertrophy of Prostate

Date of op.: Aug. 4, 1948

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of _____

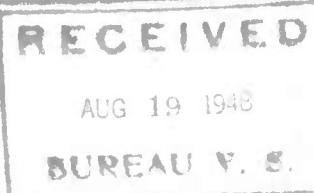
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James M. Fadell, M.D. M. D. or other

Address: 1835 Eye Street Date signed: Aug. 16 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08605

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

8 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

JAMES HENRY VERMILLION

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Married

6. (b) Name of husband or wife

Mary A. Vermillion

7. Birth date of deceased (mo., day, yr.)

March 17th 1885

8. AGE:

Years
63

Months

Days

If less than one day
hrs. min.

9. Birthplace

Upper Marlboro Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Baltimore Transit Co.

12. Name

Julius Vermillion

13. Birthplace

Maryland

14. Maiden name

Emma Boswell

15. Birthplace

Maryland

16. Name

Mary A. Vermillion

Address

4415 Wheeler Rd. S.E.

17. Burial

Date thereof
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Lorraine Park

Location

Baltimore Md.

18. Funeral director

A. W. Chambers Co.

Address

517 11th St. S.E.

19. Date rec'd by registrar

Aug. 27 1948

(Date rec'd by registrar)

Carrie F. Campbell

Registrar

M.D. or other

Address

2904 Nichols Ave. S.E.

Date signed

8-26-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

none

2.(a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 26 1948 at 4:05 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 8 1948 to August 15 1948

and that I last saw him alive on

August 26 1948

19 1948

Immediate cause of death

Congestive heart failure

DURATION

6 mo.

Due to

arteriosclerosis H. D.

2 yr

Due to

Generalized arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. O'Leary M.D.

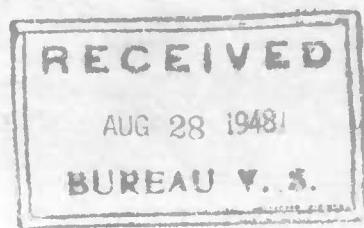
M.D. or other

Address

2904 Nichols Ave. S.E.

Date signed

8-26-48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08606

CERTIFICATE OF DEATH

245

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

Prince Georges

College Park, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Leslie Bell Ward

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

widowed

6. (b) Name of husband or wife

Terinal L. Ward

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

June 20, 1874

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Somerset Co., Md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

t8. Funeral director

Address

t9. Date rec'd by registrar

A. J. Rusey

Somerset Co., Md

Mary Ellen Richardson

Somerset Co., Md

Mrs Grace Long

4605 Amburst Rd. College Park

Baptist Cemetery

Doromoke Md

Hyattsville Md

J. Gaschis son

Hyattsville Md

Mrs. Jas. Devere

Wife

Registrar

Date signed 8-9-45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For whom infants give residence of mother)

State Delaware County New Castle

City or town Wilmington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2207 - West Street

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1948, at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h alive on 19.

Immediate cause of death

Transt. Congestive
Heart Failure

DURATION

1 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

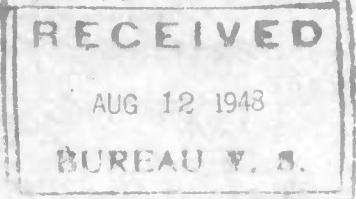
Injured at work?

23. SIGNATURE

John J. Maloney Esq.

M.D. or other

Address Cheltenhy Hyattsville Date signed 8-9-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH: PRINCE GEORGE'S
County.....

City or town..... BERWYN
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred: 4700 BERWYN Rd

How long in hospital or institution? —

3. (a) FULL NAME
FRANCES WILLIAMS WERBER

4. Sex FEMALE WHITE 5. Color or race WIDOWED 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife WERBER JR. 7. Birth date of deceased (mo., day, yr.) 30 AUG 1858 6. (c) If alive, give age years

8. AGE: Years 89 Months 11 Days 21 If less than one day — hrs. — min.

9. Birthplace BULLOCK CO. GEORGIA
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business WASHINGTON ROACH

12. Name ABRAHAM WERBER CO.

13. Birthplace UNKNOWN

MOTHER FATHER 14. Maiden name FRANCES Peterson

15. Birthplace UNKNOWN

16. Informant RALPH H CASE

Address BERWYN, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 24 1948
(month) (day) (year)

Cemetery or crematory Glenwood Cemetery

Location Washington, DC

18. Funeral director T. Garcia Sand

Address Hyattsville, MD.

19. Date rec'd by registrar Aug. 22 1948 Mrs. Joe Severe
(Date received by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Prince George's

City or town BERWYN, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4700 BERWYN RD -
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (b) Social Security Number —

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 August 1948 at 7:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from OCTOBER 1946 to AUGUST 1948 and that I last saw her alive on 20 AUGUST 1948

Immediate cause of death CEREBRAL THROMBOSIS DURATION 1 da

Due to GENERALIZED DURATION 54R +
ARTERIOSCLEROSIS

Due to MULTIPLE CONTUSIONS DURATION BACK & RIGHT LEG (CONTRIBUTING)

Other conditions AS ABOVE (Include pregnancy within 3 months of death)

Major findings of operations Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of July 7, 1948

Where did injury occur? BERWYN PR GEO MD (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) HOME

Means of injury FALL ON STAIRS Injured at work? NO

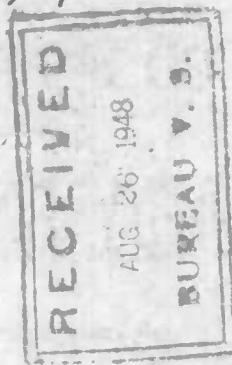
23. SIGNATURE DR. ELIENNE

Address BERWYN, MD. M. D. or other OVER

Date signed 8-21-48

Deputy MEDICAL

EXAMINER -
DR JOHN T MALONEY
NOTIFIED 7⁴⁵ PM 21 Aug '48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 238

1. PLACE OF DEATH:

County. Prince George
City or town. Greenbelt

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Edith L Wilkinson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife. James L Wilkinson

7. Birth date of deceased (mo., day, yr.) March 12 - 1875

8. AGE: Years Months Days If less than one day
73 hrs. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation. Housewife

11. Industry or business

12. Name. Eli Moulden

13. Birthplace Md.

14. Maiden name. Martha E. Riggs

Va.

16. Informant. Edith W. Lyles

Address 11-K Ridge Rd. Greenbelt Md.

17. Burial. Date thereof. August 10th 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory. Arlington National

Location. Arlington, Va.

18. Funeral director. Wm. J. Malley

Address 3200-B. I. Ave. Mt. Rainier Md.

19. Aug. 10th 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. Maryland County. Prince George

City or town. Greenbelt

(If outside city or town limits, write RURAL and give nearest town)

Street No. 11-K Ridge Rd

(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH. 8/16 1948 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1948 to August 1948

and that I last saw her alive on August 15, 1948

Immediate cause of death. Respiratory failure

DURATION

Due to. Cardiac failure - Chronic Pulmonary Congestion

Due to. Arteriosclerosis. Heart disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

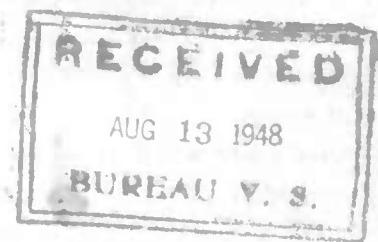
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE. William L. Lyles, Jr. M. D. or other

Address. 30-B Ridge Rd. Greenbelt Md. Date signed. 8/17/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0860

234

1. PLACE OF DEATH:

County

Prince George

City or town Silver Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred

Transient
Naylor and Meltzer Roads

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

Married

6. (b) Name of husband or wife

Romayne Williams

6. (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.)

May 17, 1905

8. AGE:

Years
43

Months

Days

If less than one day

hrs. min.

9. Birthplace

Maryland

(Town, county and state)

10. Usual occupation

Attendant

11. Industry or business

St. Elizabeth Hospital

MOTHER FATHER

George D. Williams

Maryland

Josie D. Dean

Maryland

16. Informant

Mr. Agnes Andrews

Address 3441 34th Street

17. Burial

Date thereof Aug 28, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland Md

18. Funeral director

F. Gasch's Son

Address Hyattsville Md

19. (Date rec'd by registrar)

1948

Date signed 8-27-48

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District Columbia

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 720 Virginia Ave. N.E.

(If rural give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

Non anæsthetic and shock caused chest skull abdomen, periton

Due to

Fracture of left forearm and right clavicle

(Include pregnancy within 8 months of death)

Major findings or operations

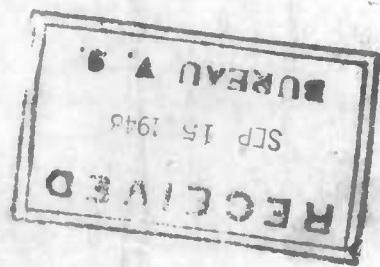
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8-26-48Where did injury occur Silver Hill (City or town) D.C. (County) Md. (State)Injured at home, farm, industry, public place (where?) Pub. placeMeans of injury fall of auto in car (method) Automobile (place)Helpful medical exposure Medical WorkOther Helpful medical exposure23. SIGNATURE A. J. Williams M. D. or other PhysicianAddress 720 Virginia Ave. N.E. Date signed 8-27-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH: Prince Georges
County.....
City or town..... Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 5 mos., 9 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 1 yr., 5 mos., 9 days

138
2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... D. C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 115 Forrester St., S. W.
(If rural, give LOCATION)

3. (a) FULL NAME

WILLIAMSON JAMES EDWARD

3. (b) Social Security Number

4. Sex	5. Color or race	6. (v) Single, married, widowed, or divorced		
Male	White	Married		
6. (b) Name of husband or wife..... Sarah J. Williamson				
7. Birth date of deceased (mo., day, yr.)		6. (c) If alive, give age..... 31 years		
8. AGE:	Years	Months	Days	If less than one day
37	37	1	19	hrs. min.
9. Birthplace..... Ellisville, Mississippi			(Town, county, and state)	
10. Usual occupation..... Machinist				
11. Industry or business.....				
12. Name..... John D. Williamson				
13. Birthplace..... ? Mississippi				
14. Maiden name..... Ethel A. Eokes				
15. Birthplace..... ? Mississippi				
16. Informant..... Deceased				
Address.....				

17. Removal..... Date thereof..... Aug 14, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Washington, D. C.
Location..... Chambers Funeral Home
18. Funeral director.....
Address 517 - 11th St., S.E., Washington, D.C.
19. Date rec'd by registrar..... Aug 14, 1948
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 14, 1948, at 1145 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/25, 1947, to 8/14, 1948, and that I last saw him alive on 8/14, 1948.

Immediate cause of death..... pulmonary tuberculosis

DURATION..... 10 yrs + 5 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Scene of injury..... Injured at work?

23. SIGNATURE..... Daniel Leo Finegan M.D.
M. D. or other.....
Address..... Glenn Dale, Md., Date signed..... 8/14/48

RECEIVED
AUG 24 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1310

08611

232

Reg. Dist. No.

1. PLACE OF DEATH:

County... Prince George's
 City or town... Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 year

Hospital, Institution, or street address where death occurred:
Hills Candy Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State... Maryland County... Prince George's
 City or town... Upper Marlboro
(If outside city or town limits, write RURAL and give nearest town)

Street No... Hills Candy Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary Elizabeth Wilson

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

Female Colored Widowed.

6. (b) Name of husband or wife..... William Wilson

7. Birth date of deceased (mo., day, yr.)..... January 1, 1871

8. AGE: Years 77 Months 7 Days 26 Hours 0 min. 0 less than one day

9. Birthplace..... Maryland

(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... William Wood

12. Name..... Maryland

13. Birthplace.....

14. Maiden name..... Elizabeth Young

15. Birthplace..... Maryland

16. Informant..... Thompson Wilson

Address..... Upper Marlboro, Md

17. Burial..... Aug. 29, 1948

(Burial, cremation, or removal. Which?)

Date thereof... Aug. 29, 1948

(Month) (day) (year)

Cemetery or crematory..... Union Methodist

Location..... Upper Marlboro, Md

18. Funeral director..... Ritchie Bros.

Address..... Upper Marlboro, Md

19. Aug. 28, 1948

(Date rec'd by registrar)

Ruth Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... August 26, 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 40 to Aug. 26, 1948

and that I last saw her alive on Aug. 12, 1948

Immediate cause of death..... Cancer of heart

heat failure

Due to..... Endoscopy

Due to..... renal disease

Other conditions.....

(Include pregnancy within 6 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

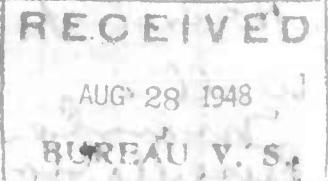
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Jan. 2, 1949

M. D. or other.....

Date signed..... Jan. 2, 1949



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08612

CERTIFICATE OF DEATH

Reg. Dist. No. 239

(Please write clearly and legibly)

(Give correct age)

(If outside city or town limits, write RURAL and give nearest town)

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

None

1. PLACE OF DEATH:

County.

City or town.

Dr. Geo. C.
Laurel - Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Warren's Hosp.

How long in hospital or institution?

3. (a) FULL NAME

Charles Chester Yoder

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M M married
Esther M. Yoder

6. (b) Name of husband or wife.

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

March 6, 1892

8. AGE: Years Months Days Less than one day

56 5 18 hrs. min.

9. Birthplace

Warren's Hosp.

(Town, county, and state)

10. Usual occupation

Motorman

Cap. Transit Co.

11. Industry or business

Adam Yoder

12. Name

MOTHER FATHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Date rec'd by registrar

Signature of Registrar

Address

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.

City or town.

Street No.

2.(a) if veteran, name war.

3. (b) Social Security Number

578-10-6615

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Coronary Thrombosis

DURATION 8 mo.

Due to Myocarditis

1 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

